		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031690

Facility Name: SULLIVAN HEALTH CARE CENTER

Address: 11 HAWTHORNE LN (Number) SULLIVAN (City) 61951 (Zip Code)

County: MOULTRIE

Telephone Number: 217-728-4327 **Fax #** 217-728-2263

IDPA ID Number: 51-0271905

Date of Initial License for Current Owners: 12/1/1986

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Karl Baker, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2002 to 6/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Junior Foster, THSCLLC, Mgt. Co for
(Title) SULLIVAN HCC

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44895	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	Private Pay	Other	Total	
8	SNF	6,768	3,457	4,175	14,400	8
9	SNF/PED	0	0	0		9
10	ICF	6,858	2,980	0	9,838	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	13,626	6,437	4,175	24,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.99%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started #######

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date ####### NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 4,175

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: ####### Fiscal Year: ########

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SULLIVAN HCC # 31690 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	120,943	8,721	5,556	135,220		135,220	(4,962)	130,258			1
2	Food Purchase		108,369		108,369		108,369	(470)	107,899			2
3	Housekeeping	38,561	9,698	32,844	81,103		81,103		81,103			3
4	Laundry	18,538	6,717	21,891	47,146		47,146		47,146			4
5	Heat and Other Utilities			118,124	118,124		118,124		118,124			5
6	Maintenance	31,288	3,843	29,721	64,852		64,852		64,852			6
7	Other (specify):*			3,700	3,700		3,700		3,700			7
8	**TOTAL General Services**	209,330	137,348	211,836	558,514		558,514	(5,432)	553,082			8
	B. Health Care and Programs											
9	Medical Director			15,510	15,510		15,510		15,510			9
10	Nursing and Medical Records	988,527	74,136	5,297	1,067,960		1,067,960		1,067,960			10
10a	Therapy		370	299,541	299,911		299,911		299,911			10a
11	Activities	32,125	686	2,772	35,583		35,583		35,583			11
12	Social Services	56,896	152	2,627	59,675		59,675		59,675			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,077,548	75,344	325,747	1,478,639		1,478,639		1,478,639			16
	C. General Administration											
17	Administrative	46,619	(2,851)	6,009	49,777		49,777		49,777			17
18	Directors Fees											18
19	Professional Services			228,679	228,679		228,679	2,850	231,529			19
20	Dues, Fees, Subscriptions & Promotions			51,246	51,246		51,246	(30,546)	20,700			20
21	Clerical & General Office Expenses	61,903	17,901	59,208	139,012		139,012	(37,454)	101,558			21
22	Employee Benefits & Payroll Taxes			211,345	211,345		211,345	5,289	216,634			22
23	Inservice Training & Education			710	710		710		710			23
24	Travel and Seminar			3,423	3,423		3,423	995	4,418			24
25	Other Admin. Staff Transportation			2,849	2,849		2,849		2,849			25
26	Insurance-Prop.Liab.Malpractice			126,221	126,221		126,221	3,144	129,365			26
27	Other (specify):*			293	293		293		293			27
28	**TOTAL General Administration**	108,522	15,050	689,983	813,555		813,555	(55,722)	757,833			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,395,400	227,742	1,227,566	2,850,708		2,850,708	(61,154)	2,789,554			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SULLIVAN HCC #31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			130,812	130,812		130,812	(11,999)	118,813			30
31	Amortization of Pre-Op. & Org.			15,702	15,702		15,702	(15,702)				31
32	Interest			421,791	421,791		421,791	(1,436)	420,355			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,999	2,999		2,999		2,999			35
36	Other (specify):*											36
37	**TOTAL Ownership**			571,304	571,304		571,304	(29,137)	542,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,307	21,348	185,655		185,655		185,655			39
40	Barber and Beauty Shops							(955)	(955)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,249	67,249		67,249		67,249			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		164,307	88,597	252,904		252,904	(955)	251,949			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,395,400	392,049	1,887,467	3,674,916		3,674,916	(91,246)	3,583,670			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,424)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ #VALUE!		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	469	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #VALUE!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #VALUE!		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SULLIVAN HCC

ID# 31690

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Income	$		1
2	Barber and Beauty Revenue	(955)		2
3	(Gain)/Loss on Sale of Assets			3
4	Miscellaneous (Income)/Expense		21	4
5	Adjust Depreciation Expense to Schedule XI	(11,999)	30	5
6	Raw Foods Rebate	(470)	2	6
7	Adjust R/E taxes to actual			7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46	Costs (Schedule VII)		Var	46
47				47
48	0	0	0	48
49	**Total**	(13,424)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	1
2	Food Purchase	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	2
3	Housekeeping	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	3
4	Laundry	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	4
5	Heat and Other Utilities	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	5
6	Maintenance	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	6
7	Other (specify):*	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	7
8	**TOTAL General Services**	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	8
	B. Health Care and Programs													
9	Medical Director	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	9
10	Nursing and Medical Records	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	10
10a	Therapy	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	10a
11	Activities	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	11
12	Social Services	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	12
13	Nurse Aide Training	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	13
14	Program Transportation	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	14
15	Other (specify):*	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	15
16	**TOTAL Health Care and Programs**	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	16
	C. General Administration													
17	Administrative	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	17
18	Directors Fees	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	18
19	Professional Services	#VALUE!	2,850	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	19
20	Fees, Subscriptions & Promotions	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	20
21	Clerical & General Office Expenses	#VALUE!	(11,809)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	21
22	Employee Benefits & Payroll Taxes	#VALUE!	5,289	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	22
23	Inservice Training & Education	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	23
24	Travel and Seminar	#VALUE!	995	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	24
25	Other Admin. Staff Transportation	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	25
26	Insurance-Prop.Liab.Malpractice	#VALUE!	3,144	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	26
27	Other (specify):*	#VALUE!	0	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	27
28	**TOTAL General Administration**	#VALUE!	469	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SULLIVAN HCC **#** 31690 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	30
31	Amortization of Pre-Op. & Org.	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	31
32	Interest	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	32
33	Real Estate Taxes	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	33
34	Rent-Facility & Grounds	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	34
35	Rent-Equipment & Vehicles	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	35
36	Other (specify):*	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	36
37	**TOTAL Ownership**	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	38
39	Ancillary Service Centers	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	39
40	Barber and Beauty Shops	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	40
41	Coffee and Gift Shops	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	41
42	Provider Participation Fee	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	42
43	Other (specify):*	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	43
44	**TOTAL Special Cost Centers**	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	45

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		See attached listing				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Midamerica Care Foundation	100.00%	$ 0	$	1
2	V	19	Professional Services		Midamerica Care Foundation	100.00%	2,850	2,850	2
3	V	20	Dues, Fees, Subscriptions & Promotions		Midamerica Care Foundation	100.00%	0		3
4	V	21	Clerical & Other General Office	12,386	Midamerica Care Foundation	100.00%	577	(11,809)	4
5	V	22	Employee Benefits		Midamerica Care Foundation	100.00%	5,289	5,289	5
6	V	24	Travel & Seminar		Midamerica Care Foundation	100.00%	995	995	6
7	V	26	Insurance		Midamerica Care Foundation	100.00%	3,144	3,144	7
8	V	0	0		0	0.00%			8
9	V	0	0		0	0.00%			9
10	V	0	0		0	0.00%			10
11	V	0	0		0	0.00%			11
12	V	0	0		0	0.00%			12
13	V	0	0		0	0.00%			13
14	Total			$ 12,386			$ 12,855	$ * 469	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Patient Days	250,040	8	$ 0	$	24,238	$ 0	1
2	19	Professional Services	Patient Days	250,040	8	29,397		24,238	2,850	2
3	20	Dues, Fees, Subscriptions & Prom	Patient Days	250,040	8	0		24,238	0	3
4	21	Clerical & Other General Office	Patient Days	250,040	8	5,950		24,238	577	4
5	22	Employee Benefits	Patient Days	250,040	8	54,561		24,238	5,289	5
6	24	Travel & Seminar	Patient Days	250,040	8	10,260		24,238	995	6
7	26	Insurance	Patient Days	250,040	8	32,434		24,238	3,144	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 132,602	$		$ 12,855	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Sullivan Class 5(G) Bonds		X	Mortage	VARIES	12/1/1986	$ 3,685,000	$ 3,981,360	33329	0.1	$ 393,266	1
2	Moultrie County Treasurer		X	Past Due R/E Taxes	Varies	4/1/1991	188,072	58,526		0.09	5,267	2
3	N/P - Gold Bank LOC			Operational	Varies	4/1/2002	265,797	265,797		0.0875	23,257	3
4												4
5												5
	Working Capital											
6	Interest Income		X								(1,436)	6
7	H/O Interest Income											7
8												8
9	TOTAL Facility Related						$ 4,138,869	$ 4,305,683			$ 420,355	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,138,869	$ 4,305,683			$ 420,355	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SULLIVAN HCC COUNTY MOULTRIE

FACILITY IDPH LICENSE NUMBER 31690

CONTACT PERSON REGARDING THIS REPORT Karl Baker, BKD, LLP

TELEPHONE 314-231-5544 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior BRICK & BLOCK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 218,190
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 7,170
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	28,000		$ 10,000	1
2					2
3	TOTALS	28,000		$ 10,000	3

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	123		86	75	$ 2,161,672	$ 72,056	30	$ 72,056	$	$ 1,342,554	4
5							-				5
6							-				6
7							-				7
8							-				8
	Improvement Type**										
9	Improvements 1987			87	256,321	8,839	29	8,839		148,474	9
10	Improvements 1989			89	29,797	1,986	15	1,986		14,113	10
11	Improvements 1991			91	57,240		7			58,009	11
12	Improvements 1992			92	12,364		7			12,364	12
13	Improvements 1993			93	42,467		7			45,257	13
14	Improvements 1994			94	34,387	600	10	600		34,387	14
15	Improvements 1995			95	33,877	3,388	10	3,388		27,710	15
16	Improvements 1996			96	55,970	2,799	20	2,799		29,023	16
17	Painting and Wall Border			97	170	6	30	6		36	17
18	Grease Trap			97	1,502	75	20	75		476	18
19	Hopper with Trim			97	2,095	105	20	105		655	19
20	Repair Rubber Roof			97	12,509	1,251	10	1,251		7,818	20
21	Med Room Remodel			97	2,379	119	20	119		773	21
22	Water Heater- 120 Gallon			98	3,300	330	10	330		1,568	22
23	3 Water Heaters			98	10,200	1,020	10	1,020		5,440	23
24	Canopy at Front Entrance			99	5,274	352	15	352		1,377	24
25	Bathroom Remodel			99	4,330	289	15	289		1,131	25
26	Shower Remodel			99	24,162	1,611	15	1,611		6,040	26
27	Booster Heater			99	900	90	10	90		398	27
28	Booster Heater Dishwasher			99	629	63	10	63		278	28
29	Parking Lot Concrete			99	25,884	1,726	15	1,726		6,759	29
30	Electric Heater			99	243	49	5	49		215	30
31	Glass Windows			2000	2,600	260	10	260		672	31
32	Down Sprout System			2002	9,150	915	10	915		1,601	32
33	2003 Depreciation Adjustment					11,999	-		(11,999)		33
34							-				34
35							-				35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Gutters & Downsprouts	2002	$ 1,154	$ 115	10	$ 115	$	$ 183	37
38	Heating & A/C Units	2002	5,868	838	7	838		1,327	38
39	300 Hall Renovation	2002	10,999	367	30	367		428	39
40	Exterior Renovation	2002	23,295	777	30	777		906	40
41	Install Fire Safety Door	2002	1,156	58	20	58		63	41
42	New Rooftop A/C	2003	7,886	789	10	789		789	42
43	K-2000 Water	2003	9,359	936	10	936		936	43
44					-				44
45					-				45
46					-				46
47					-				47
48					-				48
49					-				49
50					-				50
51					-				51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,139	$ 113,808		$ 101,809	$ (11,999)	$ 1,751,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 366,908	$ 15,489	$ 15,489	$	Various	$ 311,378	71
72	Current Year Purchases	19,866	1,515	1,515		Various	1,515	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 386,774	$ 17,004	$ 17,004	$		$ 312,893	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			-	$	$	$	$		$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,245,913	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,812	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,813	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,999)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,064,653	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost		
92		$		92
93				93
94				94
95		$		95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 2,999 Description: See attached detail for rental expense
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,995	$ 113,636	$ -	1,995	$ 113,636	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,141	51,254	-	1,141	51,254	2
3	Licensed Recreational Therapist		hrs		-	-	-			3
4	Licensed Physical Therapist	10a, 3	hrs		2,430	134,652	-	2,430	134,652	4
5	Physician Care	0	visits		-	-	-			5
6	Dental Care	0	visits		-	-	-			6
7	Work Related Program	0	hrs		-	-	-			7
8	Habilitation	0	hrs		-	-	-			8
9	Pharmacy		# of prescrpts		-	-	-			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs		-	-	-			10
11	Academic Education	0	hrs		-	-	-			11
12	Exceptional Care Program	0			-	-	-			12
13	Other (specify):				-	-	-			13
14	TOTAL			$	5,566	$ 299,542	$	5,566	$ 299,542	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 139,519	$	1
2	Cash-Patient Deposits	18,211		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	380,987		3
4	Supply Inventory (priced at)	11,386		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	279		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 550,382	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	3,064,303		14
15	Leasehold Improvements, at Historical Cost	45,289		15
16	Equipment, at Historical Cost	386,774		16
17	Accumulated Depreciation (book methods)	(2,038,731)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	384,930		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(216,853)		20
21	Restricted Funds	15,833		21
22	Other Long-Term Assets (spc			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,651,545	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,201,927	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 179,910	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,211		28
29	Short-Term Notes Payable	265,797		29
30	Accrued Salaries Payable	93,389		30
31	Accrued Taxes Payable (excluding real estate taxes)	76,217		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,978,727		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	56,409		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,668,660	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,981,360		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,981,360	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,650,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,448,093)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,201,927	$	48

***(See instructions.)**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,995,577)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,995,577)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(452,516)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (452,516)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (7,448,093)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,626,488	1
2	Discounts and Allowances for all Levels	(323,398)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,303,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	630,574	6
7	Oxygen	6,207	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 636,781	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	955	13
14	Non-Patient Meals	4,962	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	222,845	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,842	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,489	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 281,093	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,436	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,436	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,222,400	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	558,514	31
32	Health Care	1,478,639	32
33	General Administration	813,555	33
	B. Capital Expense		
34	Ownership	571,304	34
	C. Ancillary Expense		
35	Special Cost Centers	185,655	35
36	Provider Participation Fee	67,249	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,674,916	40
41	**Income before Income Taxes (line 30 minus line 40)****	(452,516)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (452,516)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	6,454	6,454	$ 187,545	$ 29.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,041	7,041	159,333	22.63	3
4	Licensed Practical Nurses	8,923	8,923	194,106	21.75	4
5	Nurse Aides & Orderlies	38,969	38,969	419,013	10.75	5
6	Nurse Aide Trainees	2,037	2,037	22,147	10.87	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,082	3,082	32,125	10.42	10
11	Social Service Workers	4,623	4,623	56,896	12.31	11
12	Dietician	14,290	14,290	120,943	8.46	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,865	1,865	31,288	16.78	17
18	Housekeepers	3,411	3,411	38,561	11.30	18
19	Laundry	1,812	1,812	18,538	10.23	19
20	Administrator	1,832	1,832	46,619	25.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,859	3,859	61,903	16.04	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	811	811	6,383	7.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,009	99,009	$ 1,395,400 *	$ 14.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 5,556	1, 3	35
36	Medical Director	98	15,510	9, 3	36
37	Medical Records Consultant	21	1,570	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	78	3,727	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,627	11, 3	44
45	Social Service Consultant	40	2,627	12, 3	45
46	Other(specify) 0				46
47					47
48					48
49	TOTAL (lines 35 - 48)	388	$ 31,617		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Cassidy, Lori McNulty, John Keand	Admin.	0	$ 46619
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,619

B. Administrative - Other

Description	Amount
NOTES PAYABLE	$ 6,009
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,009
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 9479
Purchased Service	Various	760
Data Processing	Various	7661
Accounting	Various	7994
Professional Services	Various	2030
Management Fees	Various	192755
Trustee Expense	Various	8000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 228,679

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,488
Unemployment Compensation Insurance	-
FICA Taxes	109,798
Employee Health Insurance	27,708
Employee Meals	-
Illinois Municipal Retirement Fund (IMRF)*	-
Other Benefits	6,351
	-
	-
Home Office Allocation	
TOTAL (agree to Schedule V, line 22, col.8)	$ 211,345

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,201
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	10,499
Advertising & Public Relations	30,546
Home Office Allocation	
Less: Public Relations Expense	(-)
Non-allowable advertising	(30,546)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,700

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,423
Seminar Expense	-
Business Meals	
Home Office Allocation	
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,423

**See instructions.

Facility Name & ID Number SULLIVAN HCC # 31690 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SULLIVAN HCC # 31690 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **8653 - Illinois Health Care Assoc.**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **YES** If YES, what is the capacity? **92**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8223** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67249**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4962**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP KC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N** If no, please explain. **In progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.